Concurrent Session Two – Intervention Quality/Scientific Basis

Qairo Ali
Marlene Glassman

Qairo Ali (CDC/PPB) and Marlene Glassman (CDC/PERB) gave the same opening remarks as they did in the morning session. Marlene Glassman then introduced Sandra Klocke and Nancy Jo Hansen, both from Nebraska Health & Human Services.

Sandra Klocke and Nancy Jo Hansen
Health Department Peer
Nebraska Health & Human Services

Sandra Klocke and Nancy Jo Hansen shared information about how Nebraska decided to handle the interventions, in terms of the scientific basis and sufficiency of plan. Ms. Klocke explained that Nebraska has been in the throws of change for the past couple of years with trying to implement the Evaluation Guidance, and also changing the community planning piece. They started by combining Prevention and CARE into one statewide group, which was a change from the previous six regional groups. The composition of the group is made up of four categories. They did this in order to ensure that they had the kinds of scientific people necessary to make decisions, as well as local/sub-grantee/geographic input. She explained the four categories to be:

- ❏ *Standing Positions* which include behavioral scientists, Title III's, corrections programs and similar entities from which they need input;
- ❏ *Elected Positions* which include the sub-grantees, in terms of different types of services (counseling/testing, prevention, CARE);
- ❏ *Elected Positions* which include those from infected and impacted populations, as well as risk groups;
- ❏ *Regionally Elected Positions* which include those responsible for determining the priority populations.

Sandra Klocke said this group really started in March of 2000, so they had to work quickly to develop priority populations in preparation for a new funding cycle that started January 1st of 2001. The first step was to determine the priority populations. This entailed bringing the group together and looking at all of the data involved, including the previous year's prevention plan, the epidemiology data, the surveillance program information and local information brought in by regional representatives. They had several questions when trying to determine the priority

populations:

- ❑ Does the epi-profile support the inclusion of this particular population?
- ❑ Is there population-specific information available to support their inclusion?
- ❑ Are there scientifically based interventions available to even support working with this population?
- ❑ Are there current or potential community providers who could implement the interventions with this population?
- ❑ Should this population be broken down more in order to have more effective results?

Once they were able to answer all of these questions, they reached a consensus on what the priority populations should be. Five priority populations were identified. She explained that from there they moved to one of the new working groups called The Interventions Committee. The Interventions Committee was specifically charged with determining what the interventions for those five priority populations should be. Sandra Klocke then turned the floor over to Nancy Jo Hansen.

Nancy Jo Hansen explained the structure with the health department, and said that each of the working sub-committees has a state liaison. She is the state liaison to the Intervention Committee. Her position with the state program is sub-grant manager, which means she monitors all of the contracts that they give out throughout the state for HIV prevention activities. They first called all of the committee members together, wrote each of the populations they were given on a blackboard and then reviewed what the actual task of the committee was.

Nancy Jo Hansen then referred to a three-page worksheet that was given out to committee members to take back with them to their communities to do research about what types of interventions they thought would be effective in Nebraska, for those populations that they had been given. They divided the populations among the committee members depending on areas of expertise, etc. The members then went back to their communities and came up with interventions based on what they had seen before or had been involved with. They also went to their regional committee members for input on effective interventions, and then they completed the worksheets and sent them to Nancy Jo Hansen. She made copies of the worksheets and distributed them to the members so everyone would know what was being proposed to the statewide group. She pointed out that they were on a short timeline, which made the first year hectic and provided a learning curve for everyone.

Nancy Jo Hansen then explained that once the interventions were submitted by the committee

members, they made up packets and sent them out to everybody in the statewide group – which preceded the next statewide meeting. At that meeting, they had dozens and dozens of different interventions that were very specific – meaning they would only fit maybe one agency in the whole state. They also had generic interventions that could have been adapted to different agencies. She explained that they put all of the interventions up on flip charts around the room, and then the whole statewide group got to chop it all apart and add their own ideas. They then put all of that information into a package and sent that back out to the statewide group. She admitted that it was a very cumbersome process, but it was a process dictated by the needs of the statewide group because they wanted to have input.

At the start of the process, Nancy Jo Hansen said that the directive they gave folks was to make the interventions as specific as possible. She mentioned that in Nebraska over half of the population is in two cities, therefore, she knew there would be interventions that would be appropriate for Lincoln or Omaha that would never work in some of the rural areas. As they went through the process, she realized it was too cumbersome to send back out to the communities telling them those were the interventions they could apply for money for. They ended up taking 25-30 interventions that the committee and the statewide group decided upon and grouped them by type.

She said that the handout illustrated the five priority populations that they were given by the statewide group. Underneath each population, they identified two types of interventions that folks could actually apply for. It went back out once more to the statewide group to receive a final endorsement, and the sample she gave to these participants represented how it actually appeared in the RFA. She explained that the third page of the handout is the cover page that all of the applications had. On the form, applicants were asked to check off which population they were targeting, and which one of the eligible two interventions they were applying for money for. She said that this was a nice tool for her as the applications came in because she could tell that they had to examine and apply only for eligible interventions. This process was used to come up with interventions that have been funded for approximately the past six months.

Sandra Klocke added that part of the screening process was to look at the scientific basis that the interventions were based on. She explained that as the RFA's came in, part of the way the application was built was to look at how they planned to deliver those services and whether the plan was adequate to do what they said they were going to do in terms of the population they wanted to reach. Some of what CDC has asked them to do has been invisible to the sub-grantees because *they* didn't fully understand it, so they couldn't try to make the sub-grantees fully understand it. They chose instead to translate from their end, and the results were good.

Discussion Summary:

- A participant wanted to clarify that the committee determined the evidence or theory

based qualifications for the interventions – not the sub-grantees. Nancy Jo Hansen said that was correct. She also said that she brought a few copies of their completed RFA if anyone wanted to look at it. She also developed a "tool kit," which provided handy information for applicants, and she had sample copies of that with her as well.

- There was a question concerning #3 of the Guide to Selecting and Justifying Priority Interventions worksheet. The participant wanted to know what types of information were given in answer to this question. Nancy Jo Hansen clarified that these were not questions actually answered by the applicants. Instead, they considered this as a "think sheet" and guide for committee members.

- A participant mentioned sessions devoted to taxonomy issues and translating local definitions so that they're in sync with the intervention types and risk populations. She said she would like information on how they are handling issues such as women at significant risk, youth at significant risk and teen parent conferences. Nancy Jo Hansen stated that just because they said those interventions could be applied for, not every single one was actually applied for and certain interventions were not funded. As far as youth at significant risk, the RFA includes an entire page that must be filled out on the target population. It includes questions such as: Why is this target population at risk? What is it about this group of people that makes you want to target them for this intervention? She gave an example of a youth program called Survival Skills, in which 90% of the participants are either pregnant or parenting. Those types of issues come out in the application.

- Sandra Klocke said that they will fold into one of those populations, and that it just depends on what the project is. She noted that for a number of women at risk, the groups that they funded this year are primarily heterosexual women who will fall into that population – rather than the mothers at risk. Children are the same in that, if it's more of a general population, the youth at risk will fall into the heterosexual population. If it's definitely aimed at gay youth or MSM behaviors, then it would fall into that population. They translate that based on the information they are given, and the anticipation of what they're going to meet. Applicants are required to fill out one of the forms as part of the application to identify what populations they think they're going to meet and what numbers of populations.

- An inquiry was made as to whether there are any interventions besides those listed. Sandra Klocke responded that the only other way an intervention can get funded is through a "special projects program." They do set aside a certain amount of funds in the budget in order to allow short-term projects to be funded that would give some sub-grantees, CBO's, or other community groups an opportunity to try it out. It's a six-month funding period, and they roll these into each six-month period. These tend to be more

public information types of interventions. They did discover that they left out some good public information and media types of things. A lot of good ones came through, although they couldn't fit those into the existing interventions. They are trying to take care of those through the supplemental funding.

- A participant requested clarification on question #2 of the Guide to Selecting and Justifying Priority Interventions worksheet. She said she understood it to mean that they are determining, for the sub-contractors, the intervention programs that they would use and then translating that information to the actual interventions that the state would use (such as group level or individual level). Sandra Klocke said that is correct. She also said that the way they collect data now is client based and they are still working on a way to make that more useful. She noted that they have adopted Michigan's event form.

Charles Collins and Dale Stratford
CDC Representatives

Charles Collins and Dale Stratford presented the same introductory information about the four paths of evidence based programs discussed in the morning session. After the four paths were described (e.g., Formal Theory, Replicating Science Based Programs, Tailoring Evidenced Based Programs to Fit Local Situations, and Informal Theory), Charles Collins opened up the session to an interactive dialogue.

Discussion Summary:

- David Napp, consultant, added that when people look at informal theory it is has to be a logical logic model. Sometimes, people using boxes and arrows might be making a statement that awareness raising is going to solve the world's problems, and that won't happen. Logic to a logic model is an important part both for health department staff to assess whether that logic model is valid, and for CBO's to recognize that putting their ideas into a logic model format alone is not sufficient because it needs to pass some level of face validity.

- Charles Collins said that it is common to see established CBO's using more of the informal theory, or homegrown theory, to implement programs. He then asked, from a state health department perspective, what participants saw most often as far as the distribution among the four paths.

- A participant from Arizona said that they see a lot of replication with adaptation. They have tried to borrow things from the Compendium and make them work; however, she explained that most of their CBO's operate on budgets under $50,000 – including the evaluation component. There is so much adaptation, she worries about their ability to

replicate anything. Charles Collins concurred that because some CBO's only receive around $50,000, it almost forces the program into that column of replication with adaptation.

- A participant from Delaware said that they do a lot of replication with adaptation or a lot of informal theory. However, their next RFP will almost exclusively require formal theory. They decided to do this because their funding is low enough that adapting something starts to be very fuzzy as far as what they are replicating and what they are trying to do. Most of the staff they hire for that amount of money are not Masters or Doctorate prepared people and, therefore, their ability to come up with a completely logical and workable idea is not always there. They are giving a shot to starting with formal theory, and then developing a program from there relative to local knowledge. They they will know in two years how it is going.

- A Nebraska participant said that they have limited staff, so they usually don't have an evaluation expert for the CBO's, and sometimes not even for the state health department. She explained that they wear multiple hats and only think about evaluation on certain days when they're not dealing with staffing, monitoring, hiring etc. It seems that the Community Planning Group does this part of it, and she gets confused a lot as far as where elements happen. Nebraska has a good approach in that if the Community Planning Group develops theory based interventions, then they should do this part of it. For the CBO's, those evidence based interventions are then already in the RFA and the CBO's are charged with producing a very detailed service delivery plan that operationalizes that theory based intervention. She said she'd like to hear comments from other participants on this idea of not having CBO's recreate what the Community Planning Group should have done. It seems that the CPG comes up with interventions placed in the plan, and that an intervention would not go in the plan unless it were theory or evidence based.

- Charles Collins clarified that there were two main issues (e.g, The role of the CPG in helping to establish what constitutes an evidence based program, and then establishing some kind of standard for CBO's to meet when applying for money).

- A participant from Texas said that they try to get their CPG's to be as specific as possible about what they want to see happen in the communities and what specific interventions are expected. They encourage pulling from the Compendium, pulling from other published studies, going with hunches on programs with strong reputations, and thinking about informal theories they want to talk about. This has to be fleshed out in a work plan, and that a lot of the heavy lifting can be done through community planning. They want to have that so the health department can be as accountable as possible to the CPG to know exactly what they want to put money into. Their experience with programs in

the FT/RA columns is that there is always continual adaptation and re-calibration that has to go on because the communities are not monolithic, and risk populations/environments/needs change. She said that it is a fusion of RA and IT that goes on in the actual implementation process, which makes it difficult and messy even though they are working from a basis. She would like to see them do more work around supporting communities being able to be more specific in their instruction.

- An inquiry was posed as the whether the reference to "communities" meant the CBO's or CPG's. The Texas participant said that it has to be both. She said that they are currently doing some capacity developing with their CPG and their providers because, unless there is a shared language and understanding of what they mean by "reputationally strong" or "ILI," then there is no way that the community will have implemented the things that the CPG saw a need for. The CPG recognizes that there needs to be freedom, flexibility, and allowance for creativity and responsiveness to change. Dallas shows a high prevalence among young, gay men of color and that they really hope to see people say they need to do something, such as empowerment, that gives them a safe space to experiment with being young adults without having to sexualize that. At the same time, they want to give the CPG the freedom to say that they're not sure what the content would be because they don't see anything in the Compendium or published literature, but the feeling is that there needs to be a repeated contact intervention that addresses the following issues of self-esteem. Then they would have a more formed intervention that the CBO could use to make minor adaptations to, while keeping fidelity to the model. On the other hand, there is a lot more development work on the second example for someone to actually develop a curriculum that is responsive and addresses those factors that underlie those behaviors. She said she's looking forward to the messy mix.

- Charles Collins said that it sounded as though she is in considerable dialogue with the CBO's about what they're providing. He didn't think she could have answered that question unless she really knew the mix of programs that the CBO's had, and how some were moving from one column to another. He noted that an important aspect is that when they start looking at this issue, they may identify that a program is one place, but as they think about trying something from another intervention, or as they learn the language of behavioral science, they might move to another column. He said that capacity building, from a health department point of view, means the more they dialogue with CBO's, the more they may move and the sophistication about their program improves. He explained a dilemma that the CDC has in that they are supposed to support conservative science. This means that technically, they should support Formal Theory or Replicating Science Based Programs; however, 95 out of 100 CBO's are using the other paths. CDC has a dilemma about supporting the world of science and honoring the creativity of the community.

- Dale Stratford added that one of the things that contributes to reducing the contradictory nature of that is if they have a good rationale for the other categories. If it's well-stated and the rationale is clearly explicated in the applications, then it does help to solve that dilemma, because it provides the logic for the logic model.

- A comment was made about many Informal Theory programs not working very well and not achieving optimum results. The participant said that they are much more open to the creative ideas if they are well thought out.

- Charles Collins pointed out that people were speaking of the comfort level of their own state health department. Some state health departments feel very comfortable with informal theory and others only feel comfortable with Formal Theory and Replicating Science Based Programs.

- A Georgia participant said that before the RFP went out, they hosted training around the state in Formal Theories. They used the California HIV/AIDS Institute to convene three different trainings. She explained that they let prospective CBO's know that the RFP would be coming out soon and that they were requiring certain elements, but were hosting training to prepare them to write better proposals. They set the interventions related to ILI/GLI and the like, but they allowed the CBO's to come up with their own theories of what would work. They told the CBO's that any program they proposed would have to be theory based. In addition to that, they have members on the CPG that also serve as CBO's in the community, although this is not always the case. They didn't want to limit that information just for the state of Georgia, and limit what programs could be out there working, because a lot of the folks on the CPG were not actually out in the community doing that, so training and empowering would give them a more comprehensive opportunity to provide services.

- Charles Collins clarified that they did training on Formal Theory so that the providers could interpret some of the homegrown interventions that they were doing in terms of theory to enable them to say, "We are using modeling from social learning theory" because they were using peer educators.

- A participant from Delaware shared his concern about creativity being involved. He thought that FT and IT were equally creative, and the way to operationalize FT would be as creative as coming up with an original theory to begin with. The least creative usually are R and RA because it is a desperate attempt, with little to no money, to replicate something that is not possible with that amount of money. He reminded participants not to think of formal theory as a limit on creativity. They've done a lot of Informal Theory in the past. By starting from Formal Theory and encouraging creativity there, maybe in three years they could move back over to informal theory with much more confidence and success.

- David Napp commented that one of the logic models that underlies this whole idea is that if they help agencies articulate their interventions with more clarity and more evidence that it will lead to better delivery of interventions, which leads to risk reduction and so forth. He said this is the logic model that underlies all of this discussion. While there is a lot of work to be done with helping agencies work within these categories, it begs another question of, "Do the organizations have the capacity to monitor that they're actually implementing the programs as described?" He said they might be giving people just enough information to be dangerous because they do a very good job describing programs, but that is actually not what is happening. There is a whole second wave of responsibility that comes after this piece.

Charles Collins acknowledged that there is no right way or wrong way to work with these four paths. He then requested that the group reflect on the pros and cons to each of the strategies in order to help health departments think more about the wording of their RFA's, and what they're asking of their CBO's. The following presentations were made by each group:

Formal Theory (Pink):

Pros

- It's a well thought out intervention that is scientifically driven
- The operational components are tied to specific outcome measures
- The evaluation might be less burdensome because of the scientific links

Cons

- It requires a level of training to understand the theory components
- It might require more resources to implement
- It might require more careful monitoring – people won't necessarily understand what they're doing in terms of the theories

Replication of a Program (Green):

Pros

- ❑ It provides a "cookbook" or curriculum that makes it a lot easier than developing from scratch
- ❑ Often the "cookbooks" come with forms provided, such as pre/post test evaluation measures that have already been tested for reliability and validity
- ❑ It's less expensive because the money doesn't have to be put into development.
- ❑ There is instant approval from funders, such as the state or CDC
- ❑ There is an expected outcome against which one can measure how well it was implemented
- ❑ There is often technical assistance available.

Cons

- ❑ It's not applicable to all populations – it's specific to the populations for which it was developed
- ❑ Adaptation to local language/culture/circumstances is necessary
- ❑ It limits the input and creativity at the local level
- ❑ There might not be enough money to completely replicate the model – for example, there might not be the staffing level available that was used in the original model
- ❑ The outcomes might be too predictable – might be directed in a narrow way towards one thing and missing other things that are being accomplished
- ❑ There is skepticism of the effectiveness of those proven models – government restrictions on what is allowed have restrained evidence based models so the programs might be similarly limited by those constraints

Replication with Adaptation (Yellow):

Pros

- ❑ The adaptation allows a program to tailor something to the individual needs of a community or population and to add things that might be particular to their environment
- ❑ Could put together a program for less money than a pure replication - it might be less expensive than pure development because some of the materials/approaches/trainings have already been developed
- ❑ Because they've got a track record already, these interventions are more acceptable to

policy-makers, legislators, city councils and other funders
- ❑ Because of the adaptation element, these are more attractive to grantees than pure replications would be

Cons

- ❑ It's difficult to monitor adaptations
- ❑ It's difficult to know what the core or critical elements actually are – it's possible that a core or critical element gets adapted out of fidelity to the original model and, therefore, loses a good deal of the effectiveness
- ❑ This capacity is extremely difficult to develop and maintain – especially in CBO's or small governmental agencies where there is limited staff and experience

Informal Theory (Blue):

Pros

- ❑ There is an automatic sense of ownership – it's affirming to the agency if their intervention is developed into a theory based model
- ❑ There is buy-in by the agency and their vision by their clients who it was built upon
- ❑ The track record with the client community is not lost because the intervention has been tossed out or changed significantly
- ❑ It mirrors "client centered" approach to counseling in that the intervention starts with where the CBO is – more comfort with the intervention by the agency
- ❑ It could be ready to go with few changes
- ❑ That agency could come up with its own best practices, which would be regionally or locally specific
- ❑ The health department dialogue with the agency on theory is an opportunity for the organization to reflect on assumptions they've been making – positive opportunity for change/improvement

Cons

- ❑ The intervention is evolving – might not be structured, focused, easily replicated or easily monitored
- ❑ Risk of illogical logic model – might not even know it's illogical. This could be a capacity issue for the agency and/or health department to recognize that it's logical or illogical
- ❑ Because it's built on experience, risk of falling back into "we've always done it this way, therefore, it works" – could lead to resistance to change
- ❑ The ability for the health department or agency to respond to the issues that are revealed

– "airing dirty laundry" for political or historic reasons – or having to de-fund it when "at least we're doing something"

- ❑ Risk of political attack because it's not evidence based

Discussion Summary:

- ❖ Charles Collins said that a take-home message would be that as health departments share in the role of accountability – all four of these are accountable paths for health departments. He also said that through dialogue and working with these, programs do improve.

- ❖ Dale Stratford commented on how impressed she was with the amount of work and care that everyone has taken to deal with the issues and help lay out their complexity over the past year. She said they've really learned a lot about the kinds of problems they are facing and where assistance is needed.

- ❖ A participant wondered how far they go to stretch the definition of "scientifically based" or "evidence based" when they do the assessment of the CBO intervention plans. She gave an example of somebody doing peer outreach, thinking they could cite research that says peer outreach is a good thing, and so they check the box that says it's scientifically based.

- ❖ Charles Collins responded that CDC is sometimes asked to provide technical assistance on some of these issues. He said a state had a new contract monitor who was supposed to monitor the CBO's, and they said that one of the CBO's had been funded for years for putting condoms in a fishbowl in a gay bar. They'd fill up the bowl on Friday afternoon and go back Saturday to see how many condoms were missing. This had been funded as "outreach" in the past. The new monitor had problems with this. Mr. Collins said that many states are moving toward intervention standards so they can be sure that the interventions are appropriate. He mentioned the checklist for an effective intervention in the back of the Compendium as one approach to dealing with the question.

- ❖ David Napp commented that he appreciated the specificity of the participant's question because it was a concrete example of whether to score something "yes" or "no." While they might look to CDC to say what "is" or "is not," more might be gained from within the jurisdiction deciding together what the minimum standard is. There is a lot of learning that could come from that dialogue. He noted that the bar could keep moving higher as they move into the future, and that the minimum level for "is" or "is not" (sufficient evidence) might vary from jurisdiction to jurisdiction.

- A participant inquired as to the role of HPPG in this process. She wondered if just the health department staff goes through the exercise or if there is a role for HPPG in the process.

- Marlene Glassman responded by reading from the *Frequently Asked Questions* document under the heading "Intervention Plan Data" – page #9, question #20. She read from the page, "If community planning considers scientific evidence and justification when prioritizing interventions, and the health department then funds these interventions, does this meet requirements for scientific evidence and justification for the intervention? Or are grantees expected to submit more information?" She then read from background information about the guidance on prevention community planning, "The guidance states that at a minimum the CPG must provide a clear, concise, logical statement as to why each population and intervention given high priority was chosen." She read the response to the question, "With this in mind, intervention plans that include populations and interventions based on the priority set and the comprehensive HIV Prevention Plan will meet the requirements for evidence or theory basis for the intervention, but this is the very minimum criterion for asserting the evidence or theory basis for the intervention." She said that the community planning process will most likely not go into enough detail to provide evidence for justification for application to the target population and setting and in order to do this, she suggested that they do some of the things discussed in the session (logic models, depictions of program theory, re-writing RFP's to ask applicants to specifically provide certain information). She said that, in terms of the role of the CPG, it's really the health departments' responsibility to submit the data to CDC, but to whatever extent they want to involve HPPG (Chicago term) it would be encouraged.

- A participant from Delaware mentioned that the standards that one holds to adopt the theory vary from jurisdiction to jurisdiction, as well as agency to agency. He gave an example of an African-American church finally getting involved and being gung-ho. He said that, at this point, he'd take anything that they said. However, he noted that their initial response is not going to meet these things. He expressed his hope that they have leeway.

- Marlene Glassman responded by saying that it is their discretion and their determination to work with an agency on capacity building – that they respect their judgement.

- Dale Stratford added that she has heard project officers and folks from PERB say, "Just tell us that and let us know what the situation is." She said the main thing is that CDC wants to know how it is going and how it is progressing.

- One participant recommended that they speak with Bob Bongiovanni from Colorado. She said they have different levels of capacity in their organizations, so they have

standards that an organization has to meet to receive funding. They provide support for the organizations to go to the next level where they might get additional funding.